DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 2 0

2. STATE: MONTANA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 07/01/01

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
ARM #37.86.1001,1005

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SUPPLEMENT TO ATTACHMENT 3.1A, SERVICE 10, PAGE 1-2
SUPPLEMENT TO ATTACHEMENT 3.1B, SERVICE 10, PAGE1-2
ATTACHMENT 4.19B, SERVICE 10, PAGE 1 OF 1
SUPPLEMENT TO ATTACHMENT 3.1B, SERVICE 12b
Supplement to Attachment 3.1A, Service 12b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SUPPLEMENT TO ATTACHMT. 3.1A, SERV. 10, PAG1-2
SUPPLEMENT TO ATTACHMT. 3.1B, SERV. 10, PAG1-2
ATTACHMENT 4.19B, SERVICE 10, PAGE 1 OF 1
SUPPLEMENT TO ATTACHMENT 3.1B, SERVICE 12b
Supplement to Attachment 3.1A, Service 12b

10. SUBJECT OF AMENDMENT:
DENTAL SERVICES

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
SINGLE STATE AGENCY DIRECTOR

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Gail Gray

13. TYPED NAME:
GAIL GRAY

14. TITLE:
DIRECTOR

15. DATE SUBMITTED:
09/30/2001

16. RETURN TO:
DPHHS
GAIL GRAY, DIRECTOR
PO BOX 202951
HELENA, MT 59620-2951

ATTN: JEAN ROBERTSON

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 26, 2001

18. DATE APPROVED:
11/08/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/01/01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Spencer K. Ericson

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: September 24, 2001

MONTANA

The following limitations apply to Dental Services:

1. Diagnostic preventative dental services:
   a. Fluoride treatments are limited to six (6) month intervals.
   b. Full mouth x-rays or panorex x-rays are limited to three (3) year intervals.
   c. Bite-wing x-rays are limited to one (1) year intervals.
   d. Examinations are limited to six (6) month intervals.
   e. Prophylaxis are limited to six (6) month intervals.

2. Restoration:
   a. Gold in-lays are not a benefit.

3. Endodontic Services:
   a. Root canal services for third molars are not a benefit.

4. Periodontal Services
   a. Gingival resections are limited to treatment of gingival hyperplasia due to medication reaction.

5. Crowns and Fixed Bridges:
   a. Crowns are limited to prefabricated stainless steel or prefabricated resin crowns on posterior teeth.
   b. Fixed bridges are limited to anterior teeth.

6. Orthodontic Services are limited to:
   a. Cases that were approved and in active treatment prior to January 1 , 2000.
   b. For services provided on or after January 1, 2000, cases involving a possible Cleft/Craniofacial condition syndrome with orthodontic implications or interceptive orthodontia for recipients 12 years of age or younger with either an anterior crossbite or a posterior crossbite with shift.

7. Dental implants are not a covered benefit of the Medicaid Program.

8. Cosmetic Dental Services:
   Dental services for conditions or ailments considered cosmetic in nature are not a benefit of the Montana Medicaid program except in such cases where it can be demonstrated the physical well-being and the psycho-social well-being of the recipient are severely affected in a detrimental manner. The Department or its designated review organization will determine whether a service is cosmetic or a recipient's physical well-being and psycho-social well-being are severely affected in a detrimental manner.

9. Experimental Services:
   Services considered experimental are not a benefit of the Montana Medicaid Program.

   Experimental services include:
   a. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.
   b. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.
   c. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

10. Prior Authorization:
    The following Dental Services require prior authorization by the designated review organization: Orthodontia.

Montana will meet the requirements of Section 1905(r) of the Social Security Act and provide for the medically necessary service for which coverage is mandated by Section 1905(r).

MONTANA

1. Replacement of dentures is allowed when one of the following circumstances occur:
   a. partial dentures that are at least five years old may be replaced by full dentures.
   b. it is determined that the existing dentures are causing the patient serious physical medical problems.
   c. immediate/complete are older than 10 years.

2. Jumping is allowed for dentures between five (5) and ten (10) years old.

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MONTANA

1. Reimbursement for Dental Services shall be the lowest of the following:
   a. The provider's actual (submitted) usual and customary charge for the service.
   b. The Department's fee schedule for dental services.

2. The Department's fee schedule is calculated as follows:
   a. Dental procedures are identified through the following process:
      (1) Procedures identified through ADA/CDT coding manual; or
      (2) Dental procedures identified by the Department not identified in the current ADA/CDT.

   b. Reimbursement rates are set by one of the following methods:
      (1) The fee for a covered service shall be the amount determined by multiplying the relative value unit specified in the Relative Values for Dentists Scale by the Department conversion factor. The Department conversion factor is 30% higher for children age 20 and under. The "Relative Values for Dentists (RVD) Scale" means the scale published biennially by Relative Value Studies, Inc., 1675 Larimer, Suite 410, Denver, Colorado 80202, listing the relative value of dental services provided by dentists and denturists.

      Where a fee cannot be set using this methodology, the reimbursement is determined using the "by report" methodology. The "by report" reimbursement is paid at 80% of billed charges for children 0 through 17 years of age and 65.2% of billed charges for adults 18 years and older; or

      (2) For orthodontia services the fee is established at 85% of the provider's usual and customary charges per treatment phase. The Department will initially pay 40% of the treatment phase with the remainder to be paid in equal payments over the treatment period.